UTAH MEDICAID PROVIDER MANUAL -- PERSONAL CARE

2.000 SCOPE OF SERVICE

2.100 GENERAL POLICY

2.110 SERVICE

A. Personal care services are covered benefits when provided by a home health agency licensed in accordance with Utah Code Annotated Title 26, Chapter 21. Services are delivered by a personal care aide or a home health aide (performing only personal care-level tasks) who has obtained a certificate of completion from the State Office of Education, or a licensed practical nurse, or a licensed registered nurse. Personal care services are prescribed by a physician and are provided under the supervision of a registered nurse. Personal care services are not provided by a member of the recipient's family.

B. Personal care services are covered benefits only for recipients who receive services in their place of residence which is not an institution. Personal care service will not be prior authorized for the same day as Medicaid Home Health services.

C. Personal care services are limited by prior authorization to 60 hours per month. Personal care assessments are limited to one every six months unless prior authorized.

D. Prior authorization is required for personal care services provided after January 1, 1988.

Personal care service is an optional Medicaid (Title XIX) program authorized by Section 1905(a)(18) of the Social Security Act and 42 CFR 440.170(f).

2.130 Goal/Purpose

The purpose of personal care service is to provide supportive care to recipients in their place of residence to maximize independence and to prevent or delay premature or inappropriate institutionalization.

2.140 Objective

The objective of personal care is to enable recipients to maintain a maximal functional level in their private residence through providing minimal assistance with the activities of daily living as described in Section 2B, sub-section 2.200.

2.150 Qualified Personal Care Providers

A. The individual providing personal care must provide service under the direction of a licensed registered nurse through a licenced home health agency.

B. Persons qualified to provide personal care must be one of the following:

1. personal care aide with a certificate of completion from the State Office of Education;

2. home health aide with a certificate of completion from the State Office of Education;

3. licensed practical nurse;

4. licensed registered nurse.

C. Personal care service may not be provided by a relative of the recipient. A "relative" means a spouse, parent, stepparent, son, daughter, brother, sister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin or any such person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even if the marriage has been terminated by death or dissolution.

2.160 DEFINITIONS

2.161 Home Health Agency

"Home health agency" means a public agency or private organization, which is licensed by the Bureau of Health Facility Licensure under authority of Utah Code Annotated, Title 26, Chapter 21.

2.162 Personal Care Assessment

Personal care assessment means a visit made by a licensed registered nurse initially or at the required time of re-certification (approximately every six months) to assess recipient's functional level, the adaptability of the recipient's place of residence to the provision of personal care, to determine the capability of the recipient to participate in his own care and to identify family support systems or individuals willing to assume the appropriate level of responsibility for care when the recipient is unable to do so. The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

2.163 Prior Authorization

Prior authorization means that degree of Medicaid agency approval for payment of services required to be obtained by a licensed provider. Such approval must be obtained prior to services being provided, with the only exception being when retroactive eligibility has been established. In that case, prior authorization for services may be requested after the fact.

2.200 PERSONAL CARE SERVICE COVERAGE

2.210 Services

Services provided by the personal care provider may include:

1. receiving written instructions from the supervisor and performing only those tasks specified in the plan of care;

2. understanding that a personal care aide must not administer medications, but may remind the person to take medication, and may absolve the person who is able to self-administer medication;

3. providing minimal assistance with, or supervision of, bathing and personal hygiene including shampoo and hair care, and skin care according to recipient plan of care, and shaving with an electric razor;

4. giving nail care as written in recipient plan of care;

5. providing meal service, including special diets, meal planning, preparation, feeding if necessary, and cleanup;

6. Giving oral hygiene, including tooth or denture care and special mouth care;

7. assisting person with ambulation, including arm support, use of cane, walker, or wheelchair;

8. Assistance with bladder and/or bowel requirements or problems, including helping the patient to and from the bathroom, or assisting non-bedbound patients with bedpan routines. (May not include enemas, suppositories, or ostomy care);

9. assistance with ambulatory movement using good body mechanics;

10. taking proper measures for safety and comfort, including use of good hand washing technique, proper disposal of body waste, and explanation and application of smoking precautions;

11. administering emergency First Aid;

12. observing and reporting significant changes in the person or in the home environment;

13. performing such household services (if related to a medical need) as are essential to the recipient's health and comfort in his home. Examples of such activities would be the necessary changing of bed linens or the rearranging of furniture to enable the recipient to move about more easily in his home.

.220 Record keeping

A. The responsibility for record keeping shall rest primarily with the personal care aide, under the supervision of the assigned registered nurse. The record shall serve three purposes:

1. The record shall contain the registered nurse's instructions to the personal care aide regarding the tasks to be performed. At each review, the registered nurse shall sign the personal care aide's notes, after reviewing them and updating the instructions, if indicated.

2. The record shall contain the personal care aide's daily notes on:

    a. tasks performed;

    b. condition of the recipient;

    c. total number of hours worked;

3. The record shall contain the registered nurses's documentation of supervisory visits, which includes review of appropriateness of care, client satisfaction, and whether goals are being met.

B. At the termination of the requirement for personal care service, records maintained by the personal care provider shall be turned over to the assigned registered nurse. Such records shall be made a part of the recipient's health chart, and retained as documentation of the provision of the services.

2.230 Protection of recipients from Abuse, Neglect, or Exploitation

A. State law (UCA 55-19, Adult Protective Services) requires that any person including, but not limited to any social worker, physician, psychologist, nurse, teacher, employee of a private or public facility serving adults, who has reason to believe that any disabled adult has been subject to abuse, ne~lect or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or protective services agency (local Office of Community Operations).

B. In addition, any person required to report a suspected case of a disabled adult being abused, neglected, or exploited who willfully fails to do so, is guilty of a Class B misdemeanor.

C. Any person who abuses, neglects, or exploits a disabled adult is guilty of a third-degree felony.

2.300 HOME HEALTH AGENCY ADMISSION PROCEDURES FOR PERSONAL CARE RECIPIENTS

2.310 Requirements

A. Personal care services may be furnished by to an individual who is under the care of a physician. The physician must be the recipient's private physician, a physician on the staff of the home health agency or, if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician must write the orders on which a plan of care is established and certify the necessity for personal care service.

B. The home health agency will accept recipients for personal care on the basis of a reasonable expectation that the recipient's personal care needs can be met adequately by the agency in the recipient's place of residence. (Specific requirements for documenting recipient need are designated in Section 2.530.)

C. Personal care service must be administered by agency staff only as ordered by a physician. The nurse must immediately record and sign oral orders and obtain the physician's counter signature.

D. The initial nurse assessment by a licensed registered nurse may be provided without prior authorization for the purpose of assessing the recipient's needs and functional level and establishing the plan of care. Subsequent reassessments may be provided every six months without prior authorization. Any additional nurse assessments must have prior authorization.

2.320 Plan of Care

A. Personal care service must be delivered according to a written plan of care developed by agency staff, in consultation with the physician, and based upon physician orders. The plan of care must include the following:

1. diagnoses;

2. recipient status:

    a. mental status;

    b. rehabilitation potential (optional)

    c. Functional limitations;

3. Service need:

    a. Frequency/duration of service;

    b. personal care tasks required;

    c. equipment required (optional);

d. nutritional requirements (optional);

e. medications;

4. discharge planning or referral;

5. other identified appropriate services.

B. The plan must be signed by the licensed registered nurse and incorporated in the home health agency's permanent record for the recipient. All changes must be made in writing and signed by the licensed registered nurse of the agency staff receiving the physician's oral orders. All oral orders must be documented in writing on or before the next plan review.

C. Agency professional staff must alert the physician promptly of any changes in recipient's condition that suggest a need to alter the plan of care.

2.330 Supervision by a Registered Nurse

The licensed registered nurse must make a supervisory visit to the recipient's residence at least once every two months to assure that care is adequate and provided according to written instructions. The visit may be made either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

2.340 Periodic Review of Plan of Care

The total plan of care must be reviewed by the attending physician and signed by the home health agency personnel as often as the severity of the recipient's functional limitation requires, or at least once every six months.

2.400 LIMITATIONS

Personal care service should not be confused with services which would more appropriately be provided by persons who provide chore services in the home. Examples of chore services which are clearly not to be regarded as personal care are as follows:

1. cleaning of floor and furniture in areas not occupied by the recipient. For example, cleaning of the entire living area if recipient occupies only one small room;

2. laundry, other than that incidental to the care of the recipient. For example, laundering of clothing and bedding for the entire household, as opposed to simple laundering of the recipient's personal laundry.

2.500 PRIOR AUTHORIZATION

2.510 Requirements

A. All personal care service must be prior authorized and approved through the plan of care submitted by the home health agency.

B. Prior authorization for personal care service will be based on a physician's order and signed by a licensed registered nurse or other home health agency personnel.

C. A copy of the plan of care must be attached to prior authorization requests.

D. Prior authorization for personal care services must be obtained from the Community-Based Services Unit (CBSU).

E. When a recipient is retroactively eligible for Medicaid services, a prior authorization form must be submitted after the fact. Required documentation must include plan of care, dates of service and must be submitted with the "Request for Prior Approval" form in order for payment to be authorized.

F. The amount of service will be established and approved based on the prior authorization request. When the amount of service needed increases, a new prior authorization request must be submitted.

G. Prior authorization does not guarantee a reimbursement amount or the eligibility of the recipient. The recipient must be Medicaid eligible on the date the service is rendered.

H. Files of recipients receiving personal care services will be reviewed every nine months through a post payment audit.

2.520 Prior Authorization Process

a. New admissions (hospital discharge or physician referral):

1. Upon the initial enrollment of the recipient from a hospital discharge, or a home physician referral, a telephone contact must be made with a Community-Based Services Unit reviewer on the day of admission before 4 p.m. Telephone numbers: 538-6155 or toll free 1-800-662-9651.

2. If the admission date is a weekend or holiday, the telephone call must be received the first working day following the admission. (Example: Admit on Saturday 6/6/87, must call CBSU by Monday 6/8/87, 4 p.m.)

3. The home health agency will be given 14 days to submit to CBSU the completed “Request for Prior Approval" form, plan of care, and any supporting documentation that would substantiate the prior approved service verbally authorized.

4. Although verbal telephone authorization may be given, a written request must be received and approved before any payment can be made. Before submitting a claim, the home health a~ency must have received a copy of the "Request for Prior Approval" form back from CBSU.

B. For enrolled recipients, prior authorization forms will be required every six months upon the required re-certification date. Care and service needs and the plan of care must be reviewed and recertified by the attending physician every six months.

C. Prior authorization requests and attached documentation will be reviewed by CBSU staff. If approval is indicated, approval will be given for up to six months unless the care needs indicate that less time is required.

Mail Prior Authorization Requests to:

Prior Authorization/Personal Care
Community-Based Services Unit
Division of Health Care Financing
P.0. Box 16520
Salt La~e City, UT 84116-0580

2.530 Criteria for Review of Prior Authorization Requests

The Medicaid agency will use the following criteria to evaluate prior authorization requests. Criteria include the following:

A. prescription for personal care service by a physician as evidenced in the physician's orders; AND

B. recipient is non-bedbound; AND

C. documentation of the recipient's inability to perform two or more of the following personal care service tasks:

1. needs reminding in self-administration of medications;

2. elimination, including the use of a urinal, commode, or bedpan;

3. bathing or showering, including getting in and out of the tub or shower;

4. skin care;

5. ambulation, including use of cane, crutches, walker, or wheelchair;

6. personal grooming, including oral care, hair care, shaving (with electric razor), dressing, or nail care;

7. nutritional requirements, including meal planning, preparation, cleanup, motivation to eat, etc. AND

D. documentation that recipient's family is incapable or unwilling to provide the extent of personal care service necessary; A~D

E. documentation that the recipient needs personal care to:

1. maintain capacity to function, retard disease progression, or prevent regression and complications; OR

2. achieve satisfactory level of comfort and dignity during terminal stages of an illness; OR

3. receive assistance while recovering from an acute condition.

F. Recipient does not require any of the following home health aide procedures:

1. having vital signs or temperature taken, urine tested, urine or stool specimens collected;

2. need enemas, external catheter applied or removed, external catheter drainage tubing and bag changed or emptied; 3. bag changed on well-regulated ostomies; active or passive range-of-motion exercises; dry dressings changed.

2.540 Criteria for Review of Prior Authorization Requests for Additional Nurse Assessment

Request must include documentation that recipient's condition has changed significantly enough to require a new prior authorization.

2.550 Patient notices and Rights

The Medicaid agency will notify the personal care recipient whenever all or part of the services requested on a prior authorization request are denied. The notice will specify the services for which payment has been denied, the regulations, rules or criteria upon which the action has been taken, and the appeal rights provided. A copy of the denial notice will be mailed to the requesting personal care provider.

The personal care provider may not charge a recipient for that are denied because the provider failed to advise the that the services were not covered by Medicaid or because the provider failed to follow prior approval procedures. The provider may charge the recipient for services that are not covered by Medicaid when the provider has advised the patient in advance that the services

are not covered and the patient has agreed to pay for the services.

7.110 Personal Care Procedure Codes

A. T1001 Initial and Subsequent nurse Assessments to Establish Care Plan

Utilization Modifier SE is required to differentiate Personal Care assessment from the Home Health assessment performed in the Home Health State Plan Service category. SE signifies a Personal Care assessment rate set at 36.69% of the Home Health Agency Assessment base rate. **The SE modifier is required to be used on all State Plan Personal Care service claims for T1001.**

Limits: May be provided every six months without prior authorization. Any additional nurse assessments must have prior authorization.

B. T1019 Personal Care Service

Utilization Modifier TN is optional. This modifier is to be used to identify a rural enhancement to the routine service rate. TN signifies a Rural Enhancement rate set at 175% of the routine base rate for T1019. Use of the TN modifier is limited to service provider by a provider based in a rural county and travel a distance of 50 miles or more round trip to point of service.

In the case of multiple coordinated visits as part of a single trip, the TN modifier may only be claimed for each specific visit when the travel distance from the previous visit to that visit is 50 or more miles and the rural requirements are met.

Limits: Requires prior authorization

Personal care service will not be prior authorized for the same day as Medicaid Home Health services.